Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

C. Maynard Guest, M.D.
Executive Secretary

August 4, 1993

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

John Luke, M.D.
504 Eighth Avenue
Brooklyn, New York 11215

RE: License No. 127327
Effective Date: 8/11/93

Dear Dr. Luke:

Enclosed please find Order #BPMC 93-120 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

C. Maynard Guest

C. Maynard Guest, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER :

OF : ORDER

JOHN LUKE, M.D. : BPMC #93-120

Upon the application of John Luke, M.D., Respondent, for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 29 July 1993

Charles J. Vacanti

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JOHN LUKE, M.D.	APPLICATION FOR CONSENT ORDER

STATE OF NEW YORK)
ss.:
COUNTY OF KINGS)

JOHN LUKE, M.D., being duly sworn, deposes and says:

That on or about July 1, 1976 I was licensed to practice as a physician in the State of New York, having been issued License No. 127327 by the New York State Education Department.

I am currently registered with the New York State Education Department to practice as a physician in the State of New York for the period January 1, 1993 through December 31, 1994.

I understand that the New York State Board of Professional Medical Conduct has charged me with thirteen Specifications of professional misconduct.

A copy of the Statement of Charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to the following specifications of the statement of charges: the Fifth specification, Practicing With Negligence on More Than One Occasion, as set forth in factual

allegations A and A.1-A.8, and B and B.1-B.12; the Sixth, Seventh, Ninth and Tenth Specifications, Failing to Maintain Accurate Records, as set forth in factual allegations A, A.5, A.7, A.8, B, B.1, B.2, B.4, B.5, B.7, B.10, D, D.1, D.2, D.3, E, and E.1, and the Thirteenth Specification, Being Convicted of a Crime Under New York State Law, as set forth in paragraph H, in full satisfaction of the charges against me.

I hereby agree to the penalty of a three year suspension of license, of which the first three months shall be a period of actual suspension except to the limited extent that I may participate in Phases I and II of the Physician Prescribed Educational Program (PPEP) retraining program and the last thirty-three months shall be a period of stayed suspension, and that I be placed on probation for the entire three year period in accordance with the attached Terms of Probation, Exhibit "B".

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the

Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

JOHN LUKE, M.D.
RESPONDENT

Sworn to before me this
)(day of , 1993.

NOTARY PUBLIC

MARTIN B. ADELMAN
Notary Public, State of New York
No. 24-0018890 Qual. in Kings County
Commission Expires March 30, 19

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JOHN LUKE, M.D.	:	APPLICATION FOR CONSENT ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Date: July 22 1993

JOHN LUKE, M.D.
RESPONDENT

Date: July 22 1993

MARTIN ADELMAN, ESQ.
ATTORNEY FOR RESPONDENT

Date: _____

MARCIA E. KAPLAN
ASSOCIATE COUNSEL
BUREAU OF PROFESSIONAL
MEDICAL CONDUCT

Date: July Aug. 2, 1993

KATHLEEN M. TANNER
DIRECTOR
OFFICE OF PROFESSIONAL
MEDICAL CONDUCT

Date: _____

CHARLES J. VACANTI, M.D.
CHAIRPERSON
STATE BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JOHN C. LUKE, M.D	:	CHARGES

----------X

JOHN C. LUKE, M.D., the Respondent, was authorized to practice medicine in New York State on July 1, 1976 by the issuance of license number 127327 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 504 Eighth Avenue, Brooklyn, N.Y. 11215.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A in his office (address unrecorded) and at Methodist Hospital, 506 Sixth Street, Brooklyn, N.Y. 11215, from on or about May 14, 1986 through on or about February 22, 1988. (The identity of Patient A, and all other patients, is disclosed in the attached Appendix.) Respondent first saw Patient A, a 38 year old female, in his office on May 14, 1986. Respondent performed a physical examination and noted a 12 week size uterus, as well as a history

of primary infertility and leiomyomata uteri. Patient A had a past history of surgery for removal of fibroids in 1980. After the initial visit, Respondent saw Patient A on a number of occasions in his office. On July 1, 1987, Respondent noted Patient A's last menstrual period as May 24, 1987, calculated her estimated date of conception as February 27, 1987, and noted her uterus as 16 week size. A sonogram done on July 29, 1987 showed an 18 week size uterus containing an 8 week 2 day size fetus and two fibroids measuring approximately 5.1 cm each in diameter.

On September 11, 1987, Respondent admitted Patient A to Methodist Hospital with a diagnosis of imminent abortion and leiomyomata uteri. On admission, Patient A had vaginal bleeding and was anemic. Her hemaglobin was 10.3 and her hematocrit was 28.9. A sonogram done on September 11, 1987 found a single fetus of 16 week size with fibroids. Respondent performed a vacuum and sharp curettage procedure on September 11, 1987. The pathology report for the specimen of "products of conception" stated findings of a "large amount of blood clots mixed with fragments of decidua compacta showing areas of necrosis. No chorionic villi, trophoblastic cells or parts of embryo in the slides examined." Respondent's discharge diagnosis remained imminent abortion and leiomyomata uteri.

1. On or about September 11, 1987, Respondent performed a curettage procedure on Patient A without appropriate medical indication.

2. After the curettage procedure, the Respondent failed to recognize that the tissue obtained was not consistent with the diagnosis, and/or failed to perform further testing to establish the status of the pregnancy.

Respondent readmitted Patient A at Methodist Hospital from September 28, 1987 through September 29, 1987 with complaints of pressure in the lower abdomen for "exploratory laparotomy and possible TAH." Patient A's admitting diagnosis was "leiomyomata, chronic anemia." Her abdomen was described as "soft, non-tender." Her hemoglobin was 7 gm. and hematocrit was 19.8. The anesthesiologist refused to give Patient A anesthesia due to her low hematocrit. Patient A refused blood transfusions to raise her hematocrit. The surgery was not performed and Respondent discharged Patient A on iron therapy.

3. Respondent failed to consider and/or test for pregnancy.

4. Respondent failed to properly evaluate Patient A's anemia.

Patient A was readmitted to the hospital between October 21 and October 29, 1987 for a total abdominal hysterectomy (TAH). Respondent noted Patient A's history as "long h/o leiomyomata." On physical examination, Patient A's abdomen was described as "BS normoactive, uterus, no tenderness." Her last menstrual period (LMP) was listed as May 24, 1987. On admission, Patient A's hemoglobin was 7.9 gm. and her hematocrit was 23.4. Patient A was given three units of packed red blood cells. Respondent performed a TAH on October 22, 1987. The pathology report confirms the presence of an intact intra-uterine pregnancy

consistent with 21-22 weeks. Respondent prescribed Parlodel for the patient. Respondent signed the patient out as "leiomyomata uteri."

5. Respondent failed to perform or note an appropriate pre-operative work-up and/or failed to consider or test for pregnancy before performing the hysterectomy.

6. Respondent performed a hysterectomy without appropriate medical indication.

7. Respondent failed to record the termination of the pregnancy in the hospital record.

8. Respondent failed to inform Patient A in a timely manner that an intra-uterine pregnancy had been terminated at the time of her hysterectomy, and/or failed to note such communication.

B. Respondent treated Patient B at The Abelian Group Inc., 48-23 4th Avenue, Brooklyn, New York 11220, Lutheran Medical Center, 150 55th Street, Brooklyn, New York 11220 and Methodist Hospital, 506 Sixth Street, Brooklyn, New York, 11215, from on or about October 2, 1986 through June 13, 1988. Respondent first saw Patient B, a 26 year old female, at The Abelian Group, on or about October 2, 1986 with symptoms of "lt. ovarian cyst - (4 cm)." Respondent noted "lt adnexal mass and pain" on physical examination, and scheduled Patient B for surgery. On or about October 8, 1986, he performed an exploratory laparotomy and left ovarian cystectomy on Patient B at Lutheran Medical Center.

1. Respondent failed to perform or note an adequate history.

2. Respondent failed to perform or note an appropriate pre-operative work-up.

3. Respondent performed an exploratory laparotomy and left ovarian cystectomy without appropriate medical indication.

Respondent saw Patient B between on or about January 22, 1987 and on or about October 13, 1987 at The Abelian Group and at Methodist Hospital in connection with a pregnancy diagnosed on or about February 23, 1987. Patient B's last menstrual period was variously noted as 11/87 (sic) and 12/15/86 or 87 (sic).

4. Respondent failed to provide or note appropriate pre-natal care.

On or about October 11, 1987, Respondent admitted Patient B, who was 38 plus weeks pregnant, to Methodist Hospital with a diagnosis of pregnancy-induced hypertension for a planned caesarean section, which he performed on or about October 12, 1987.

5. Respondent diagnosed Patient B with pregnancy-induced hypertension without an appropriate work-up to substantiate this diagnosis and/or without noting such evaluation.

6. Respondent performed a caesarean section on Patient B on October 12, 1987 without appropriate medical indication.

Respondent treated Patient B between on or about January 9, 1988 and April 13, 1988 for complaints of pelvic pain. On or about April 12, 1988, Respondent admitted Patient B to Methodist Hospital and on or about April 13, 1988, he performed a laparotomy. During the laparotomy, Respondent left a lap pad inside Patient B.

7. Respondent failed to perform or note an appropriate pre-operative work-up in that he failed to rule out pelvic infection or a sexually transmitted disease before performing a laparotomy on April 13, 1988, and/or failed to note such evaluation.

8. Respondent performed the operation of April 13, 1988 in an inappropriate and negligent manner, resulting in a lap pad being left inside, causing damage to Patient B's cecum.

Patient B ran a fever of 102 on April 15, 1988, 104 on April 16, 1988, 100.4 on April 17, 1988, and 100.6 on April 18, 1988. Respondent discharged Patient B from Methodist Hospital on April 18, 1988.

9. Respondent discharged Patient B while still febrile, counter to appropriate medical practice.

The next day, on or about April 19, 1988, Respondent saw Patient B in his office. Patient B's temperature is not entered in the record of that visit.

10. Respondent failed to take and/or note Patient B's temperature.

On or about May 7, 1988, Respondent saw Patient B in his office for complaints of chronic pelvic pain and gave her Anaprox. On or about May 8, 1988, Respondent presented at the emergency room of Methodist Hospital with abdominal and pelvic pain and tenderness.

11. Respondent failed to investigate appropriately and/or failed to recognize the injury due to the retained lap pad after Patient B presented at the emergency room on May 8, 1988, and/or delayed inappropriately in operating on Patient B to remove the retained lap pad.

Respondent saw Patient B again in his office on May 21, 1988 and June 13, 1988. On June 13, 1988, he admitted Patient B to Methodist Hospital with a possible abscess and performed a laparotomy. In the Operative Report, Respondent wrote that the lap pad was "removed from the extra peritoneal layer."

12. Respondent failed to recognize the extent of the injury to Patient B's abdomen and/or the location of the lap pad.

C. Respondent treated Patient C, a 28 year old female, from on or about March 16, 1987 through on or about March 25, 1987 during her hospitalization at Methodist Hospital, Brooklyn, N.Y. Patient C was admitted to Methodist Hospital on March 16, 1987, with a history of three months of irregular periods and back pain. She had a history of past surgery, an exploratory lap for excision of fibroids in 1983. Respondent's discharge summary also gives a past history of a "herniorrhgraphy (sic) in 1985, tubal ligation and 2 or 3 other previous operations." The hospital record does not contain any record of a Pap smear, sonogram, the record of any prior operation, an STD screen, a description of the irregular bleeding, or any discussion of any other treatment. The resident noted in the hospital record that Patient C had lower abdominal pain and tenderness. The operative note of March 17, 1987 states that Patient C had a sonogram outside the hospital which showed an enlarged uterus, but there is no copy of the sonography report in the chart. Respondent's operative note states that Patient C had adhesions of the small

bowel to the anterior abdominal wall, that the bowel was injured during the dissection and repaired, and notes that the right tube and the ovary were absent. Respondent performed a total abdominal hysterectomy. Respondent did not describe the left tube and ovary in the operative report, other than to indicate that the left ovary was conserved. The pathology report showed a normal sized uterus with some adhesions, but no major abnormalities.

1. Respondent failed to perform or note an adequate history.

2. Respondent failed to perform or note an appropriate work-up of Patient C's complaints or condition.

3. Respondent failed to consider the possibility of infection, given the finding of lower abdominal discomfort, or to note such evaluation.

4. Respondent performed a laparotomy without appropriate medical indication.

5. Respondent performed a hysterectomy without appropriate medical indication.

D. Respondent treated Patient D, a 26 year old female, at The Abelian Group, Brooklyn, N.Y. and at Lutheran Medical Center, Brooklyn, N.Y., from on or about May 1, 1986 through on or about May 30, 1986. Respondent saw Patient D at The Abelian Group office on or about May 1, 1986 for complaints of lower abdominal pain for one year, every day. Respondent noted that the patient had a fibroid uterus and that he would schedule her for surgery. On May 26, 1986, Respondent admitted Patient D to Lutheran Medical Center. The hospital admission note states that the

uterus is 12 weeks size and tender, and that the duration of pain was 3-4 months. On May 27, 1986, Respondent performed a total abdominal hysterectomy and appendectomy. The uterus is described as 12 weeks size during examination under anesthesia, but no fibroid is described during laparotomy. Pathologic examination showed a minimally enlarged uterus without any significant abnormalities. The appendix was also basically normal.

1. Respondent failed to perform or note an adequate history.

2. Respondent failed to perform or note an adequate physical examination.

3. Respondent failed to perform or note an appropriate pre-operative work-up.

4. Respondent performed a laparotomy without appropriate medical indication.

5. Respondent performed a hysterectomy without appropriate medical indication.

E. Respondent treated Patient E, a 46 year old female, from on or about March 18, 1987 through on or about March 25, 1987 at Methodist Hospital, Brooklyn, N.Y. According to the resident's note, Patient E's chief complaint was "pain that lasted all the time with numbness down leg." The abdomen is noted to be tender. There is no pelvic exam on the hospital chart, no pre-operative note by Respondent, no Pap smear result, or notes concerning a pre-operative work-up. Respondent performed surgery on March 19, 1987, during which he noted and lysed omental adhesions and performed a total abdominal hysterectomy. Respondent's operative report does not include a description of

the uterus and refers to a sonogram done several months earlier, and not present in the chart, as "consistent with myomata." Pathology showed a normal uterus and cervix of normal size.

1. Respondent failed to perform or note an appropriate pre-operative work-up and/or failed to consider alternative causes of pain, or to note such evaluation.

2. Respondent performed a hysterectomy without appropriate medical indication.

F. Respondent treated Patient F, a female in her twenties, at his office (address unrecorded) and at Methodist Hospital, Brooklyn, N.Y., from on or about October 26, 1988 until October 9, 1991. Patient F arrived at Methodist Hospital at 2:50 a.m. on August 6, 1991 in prodromal labor at full term. Contractions had started at midnight. The initial monitor strip at 3 a.m. was entirely normal. Patient F was admitted at 4:15 a.m., and seen by Respondent at 9:05 a.m., at which time she was 1 cm dilated, 90% effaced. Respondent artificially ruptured Patient F's membranes and ordered Pitocin augmentation at about 9:30 a.m. At 10:45 a.m., Patient F was 4 cm dilated, and an epidural analgesic was started. At 11:15 a.m., the monitor strip shows scattered mild variable decelerations. At 12:20 p.m., she was 4 cm dilated. At 12:40 p.m., there were two variable decelerations. At 12:45 p.m., the Pitocin was off and then restarted. By 1 p.m., the strip was essentially normal. At 1:15 p.m.,there was a hyperstimulatory pattern of contractions which continued until at least 1:50 p.m., accompanied by occasional

variable decelerations. Pitocin was continued. There are no late decelerations. At 2:45 p.m. Respondent delivered Patient F by caesarean section of a baby with a normal Apgar score.

1. Respondent failed to note entries in the hospital record during the labor period.

2. Respondent ruptured Patient F's membranes during early labor without noting any medical indication for so doing.

3. Respondent ordered Pitocin for Patient F without appropriate medical indication.

4. Respondent failed to treat or note a hyperstimulatory pattern of contractions which occurred at or about 1:15 p.m.

5. Respondent performed a caesarean section on Patient F without appropriate medical indication and/or failed to note such indication in the hospital record.

G. Respondent treated Patient G, a 50 year old female, at his office (address unrecorded) and at Methodist Hospital from on or about April 17, 1989 until on or about May 3, 1989. Patient G, a 50 year old female, with a past history of a total abdominal hysterectomy seven years earlier in Jamaica, West Indies, was seen by Respondent on April 17, 1989 for pelvic pain of several months duration. On physical examination, Respondent found a pelvic mass. An ultrasound performed on April 21, 1989 contained an impression of multiple loculated pelvic cysts. The patient was admitted to Methodist Hospital on May 2, 1989 and underwent exploratory laparotomy on May 3, 1989.

1. Respondent failed to make appropriate pre-operative entries in the hospital record.

2. Respondent failed to remove the patient's left ovary, which had a 7 cm. ovarian cyst.

H. On or about March 10, 1987, Respondent was convicted upon a plea of guilty of Conspiracy in the First Degree under section 105.05, subdivision 1 of the Penal Law, a Class A misdemeanor, in that on or about and between July 11, 1985 and December 30, 1985 at Methodist Hospital and other places in Kings County, New York, Respondent acted in concert with others and agreed with others to engage in and cause the performance of the felonies of Insurance Fraud, Grand Larceny and Falsifying Business Records, by performance of the following overt acts: by diagnosing one [redacted] as suffering from an inability to conceive children; by submitting false statements to Arista Insurance Company in support of a claim by [redacted] for disability insurance monies as compensation for an alleged maternity leave; and by submitting false statements to Lawrence Insurance Group in support of a claim for insurance moneys as compensation for services related to his alleged prenatal care of [redacted] and alleged delivery of her child. Respondent was fined $1000.

I. Respondent knowingly and intentionally failed to reveal the fact of his March 10, 1987 conviction of the crime of Conspiracy in the First Degree, as required, on the registration application for the period 1/01/89 - 12/31/91, which he signed

and submitted to the New York State Education Department on or about June 23, 1988.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1993), in that Petitioner charges:

1. The facts in paragraphs A, A.7 and/or A.8.
2. The facts in paragraph H.
3. The facts in paragraph I.

FOURTH SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence on a particular occasion under N.Y. Educ. Law Sec. 6530(4)(McKinney Supp. 1993), in that Petitioner charges:

4. The facts in paragraphs A, A.3, A.5, A.6, A.7 and/or A.8.

FIFTH SPECIFICATION -

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Sec. 6530(3) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

5. The facts in paragraphs A, A.1, A.2, A.3, A.4, A.5, A.6, A.7, A.8, B, B.1, B.2, B.3, B.4, B.5, B.6, B.7, B.8, B.9, B.10, B.11, B.12, C, C.1, C.2, C.3, C.4, C.5, D, D.1, D.2, D.3, D.4, D.5, E, E.1, E.2, F, F.1, F.2, F.3, F.4, F.5, G, G.1 and/or G.2.

SIXTH THROUGH TWELFTH SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with failing to maintain a record for patients A, B, C, D, E, F and/or G which accurately reflects the evaluation and treatment of these patients under N.Y. Educ. Law Sec. 6530(32) (McKinney Supp. 1993), in that Petitioner charges:

6. The facts in paragraph A, A.5, A.7 and/or A.8.

7. The facts in paragraph B, B.1, B.2, B.4, B.5, B.7 and/or B.10.

8. The facts in paragraph C, C.1, C.2 and/or C.3.

9. The facts in paragraph D, D.1, D.2 and/or D.3.

10. The facts in paragraph E and E.1.

11. The facts in paragraph F, F.1, F.2, F.4 and/or F.5.

12. The facts in paragraph G and G.1.

THIRTEENTH SPECIFICATION

BEING CONVICTED OF A CRIME UNDER NEW YORK STATE LAW

Respondent is charged with having been convicted of committing an act constituting a crime under New York state law under N.Y. Educ. Law Sec. 6530(9)(a)(i) (McKinney Supp. 1993), in that Petitioner charges:

13. The facts in paragraph H.

DATED: New York, New York
June 8, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct

EXHIBIT "B"

TERMS OF PROBATION

1. JOHN LUKE, M.D., during the period of probation, shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession;

2. Respondent shall submit written notification to the New York State Department of Health (NYSDOH), addressed to the Director, Office of Professional Medical Conduct, New York State Health Department, Corning Tower Building, 4th Floor, Empire State Plaza Albany, New York 12237 of any employment and practice, of Respondent's residence and telephone number, or any change in Respondent's residence and telephone number, or any proposed change in Respondent's employment or practice within or without the State of New York;

3. Respondent shall not begin any new employment until after he has obtained the approval of the Director of OPMC as to the terms of the monitoring and supervision at his new employment. The monitoring and supervision required as part of the Terms of Probation shall remain in effect and shall not be interrupted or interfered with in any way.

4. Respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that Respondent has paid all registration fees due and owing to the NYSED and Respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by Respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation;

5. Respondent shall submit written proof to the NYSDOH, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) Respondent is currently registered with the NYSED, unless Respondent submits written proof that Respondent has advised DPLS, NYSED, that Respondent is not engaging in the practice of Respondent's profession in the State of New York and does not desire to register, and that 2) Respondent has paid any fines which may have previously been imposed upon Respondent by the Board or by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

6. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non renewal of permits or licenses (Tax Law section 171(27); State Finance Law section 18; CPLR section 5001; Executive Law section 32).

7. During the term of probation, Respondent's hospital practice shall be supervised and monitored by a licensed physician in his department in each hospital in which he maintains privileges ("practice supervisor"). The practice supervisor(s), and any successor practice supervisor(s), shall be selected by the chief of the department, subject to approval by the Director of OPMC. No practice supervisor shall be a personal friend or a relative of Respondent. The practice supervisor(s) shall be in a position to regularly observe and assess Respondent's professional performance and practice and shall evaluate whether Respondent's care and treatment comport with generally accepted standards of medical practice. The practice supervisor(s) shall meet bi-weekly with the Respondent to discuss his practice. Supervision by the practice supervisor(s) shall include monitoring and review of each of Respondent's hospital cases, and may include: unannounced review of Respondent's patient records; unannounced actual observation of his treatment of patients; unannounced review of his ordering, administering and inventorying of all controlled substances, interviews of Respondent, and any other reasonable means of monitoring Respondent's practice. The practice supervisor(s) shall be familiar with the Terms of Probation contained herein, and shall acknowledge his/her willingness to comply with the supervision and monitoring by executing an acknowledgement provided by OPMC. The practice supervisor(s) shall submit to OPMC quarterly reports regarding the quality of Respondent's medical practice, and certifying his compliance or detailing his failure to comply with the Terms of Probation. The practice supervisor(s) shall report immediately to OPMC any failure of the Respondent, at any time, to comply with the Terms of Probation.

8. Respondent, within the first four months of the period of probation, shall complete the evaluation phase (Phase I) of the Physician Prescribed Educational Program (PPEP), Department of Family Medicine, 475 Irving Avenue No. 200, Syracuse, N.Y. 13210. Dr. William D. Grant, Director of the PPEP, shall inform Kathleen M. Tanner, Director of OPMC, of Respondent's satisfactory completion of Phase I of the program and of the results of Respondent's evaluation.

9. Upon completion of Phase I of the PPEP and within five months of the commencement of the period of probation,

Respondent shall apply for and enroll in the reeducation phase (Phase II) of the PPEP in Syracuse. Respondent shall remain enrolled and shall fully participate in Phase II of the program, in accordance with the findings made during Phase I. Respondent shall successfully complete Phase II of the PPEP within one year of the start of his participation in Phase I of the program.

10. Failure of the Respondent to be accepted into Phase II, to remain enrolled and fully participating in Phase II, or to successfully complete Phase II, will be deemed a violation of probation.

11. During Phase II, the preceptor assigned to Respondent shall submit monthly reports to OPMC certifying that Respondent is fully participating in Phase II and shall inform Kathleen M. Tanner, Director, OPMC, of the results of the Respondent's reevaluation or reassessment at the completion of his Phase II retraining. The preceptor shall report immediately to the Director of OPMC if Respondent withdraws from the program and shall report promptly to OPMC any significant pattern of absences by Respondent. The preceptor shall acknowledge in advance his/her willingness to comply with the reporting by executing the acknowledgement provided by OPMC.

12. After Respondent has successfully completed Phase II, Respondent shall meet with an OPMC Medical Coordinator on a quarterly basis for the duration of the term of probation for review of Respondent's patient records and discussion of Respondent's medical practice to determine whether Respondent's care and treatment comport with generally accepted standards of practice.

13. Respondent shall assume and bear all costs related to compliance with the Terms of Probation.

14. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the order of the Board.

15. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her aforementioned profession in accordance with the terms of probation; provided, however, that upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the Public Health Law.